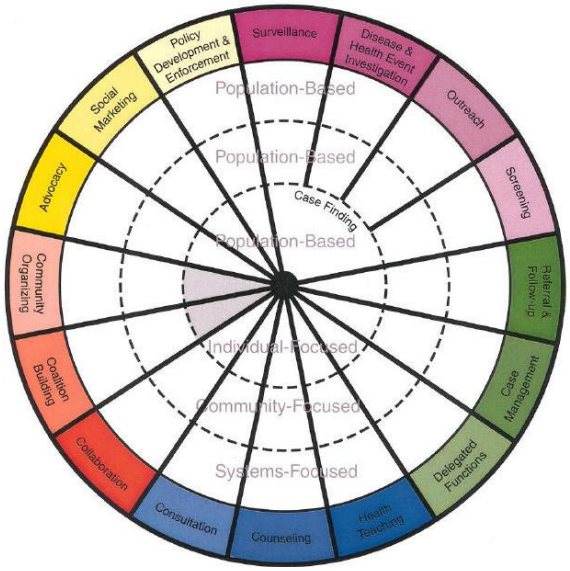
The Value of Public Health Nurses in Alaska

Our POPULATION-BASED (see Figure 1) practice

- Focuses on the **entire population**
- Is grounded in **assessment** of a community's health status and priorities
- Considers the **broad determinants** of health (i.e. social status, support networks, education, employment, culture, etc.)
- Intervenes with **communities**, **systems**, and **individuals/families**

Figure 1: Population Based Practice Wheel



We distinguish ourselves from all other nursing specialties by our adherence to the following eight tenets:

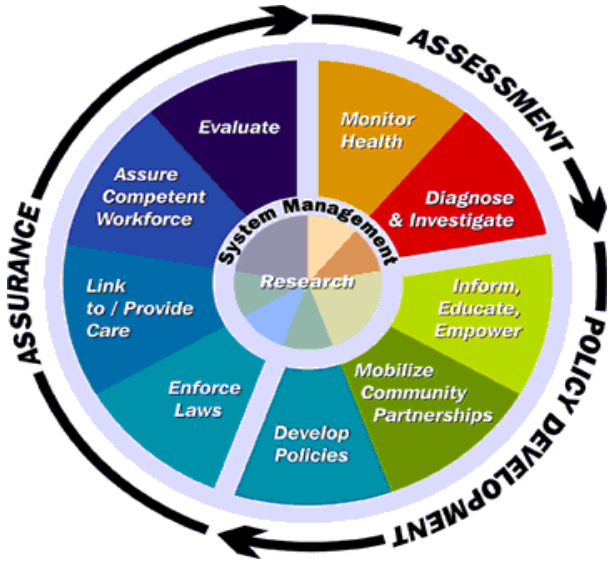
1. Assessment, policy development, and assurance processes are population-based, systematic and comprehensive.
2. All processes must include partnering with representatives of the population.
3. Primary prevention and health promotion are given priority.
4. Intervention strategies are selected to encourage and develop healthy environmental, social and economic conditions in which people can thrive.
5. An obligation to actively reach out to all who might benefit from an intervention or service, with special consideration of vulnerable groups.
6. The dominant concern and obligation is for the greater good of all the people, or the population as a whole.
    a. *The unit of care for this specialty is the population, consideration of what is in the best interest of the whole takes priority over the best interest of an individual or a group. Public Health Nurses promote the health of individuals, but this responsibility is **secondary** to their obligation to promote the health of the population.*
7. Stewardship and allocation of available resources supports the maximum population health benefit.
8. The health of the population is most effectively promoted and protected through collaboration with members of other professions and organizations.

All Alaskans can access public health nursing services. Our service priorities vary by health center and itinerant district based on community needs, available resources, and staff capacity. Our public health nurse's work time is spent in a combination of individual/family, community, and system activities which are distinct and requires a unique set of competencies.

We contribute to forming the "public health safety net" in Alaska through prioritization of the vulnerable and high risk populations -- uninsured, low-income under-insured, Medicaid beneficiaries, and patients with special health care need -- that fall outside of the medical and economic mainstream and have little or no access to stable health and social services.

Our individual clinical services are strategic actions that reflect the provision of individual clinical level services according to the 7th Essential Public Health Service – i.e. working as a safety net (see Figure 2). We educate, screen, link and refer clients to appropriate resources, while ensuring that they can access services such as newborn hearing screening, immunizations and Well Child Exams are valued and if necessary completed by the PHN if there is no other available option. Our work at the individual clinical level is coordinated with our local primary care partners in an intentional, non-competitive, and non-duplicative manner. We work with the goal of being the bridge to access to care by working to empower families/individuals to value and improve health and learn to access and use local care/resources independently.

Figure 2: Core Functions and Essential Services Wheel



Our community and system level services focus on engaging the community in assessment activities to identify gaps in culturally-competent, appropriate, and equitable health and social services. We then mobilize support and implement strategies to address these local gaps in partnership with the community. We also provide a variety of public health education to groups of community members in order to raise awareness of emerging issues and to change community norms, attitudes, practices, and behaviors.

The broad base public health knowledge and experience of public health nurses in Alaska helps reduce health care costs through promotion, prevention and early detection of health problems. Alaska's public health nurses have intimate knowledge of local community resources, community leadership, and cultural and family structures. Our skills and knowledge in combination with the trust of individuals and professionals due to our local presence prove invaluable when working to address public health issues, such as communicable disease control.

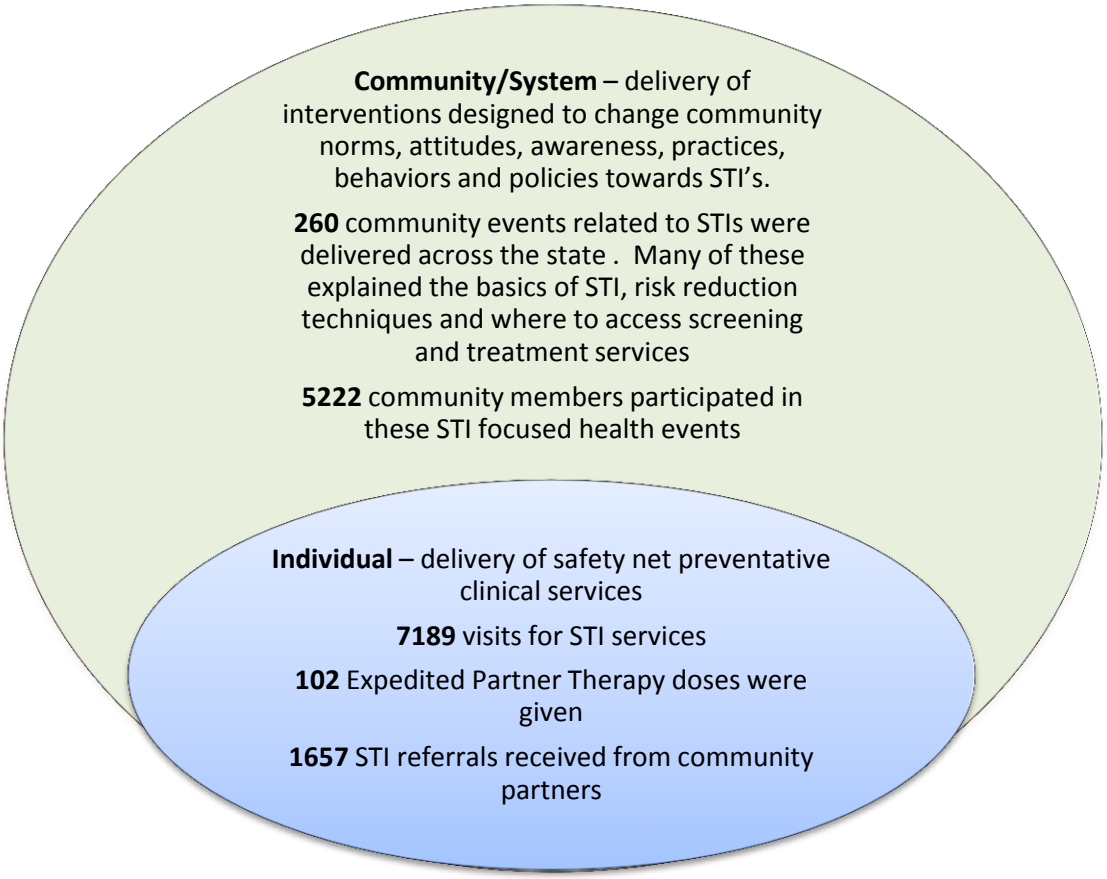
We balance community needs (identified through the process of assessment) with our professional standards of practice when deciding on a PHN response. A continuous quality improvement cycle assures all actions (Section-wide, regional and local) reflect our guiding principles.

Our work, due to its focus on the underserved populations, is not comparable with the private health care sector. There is little or no reimbursement stream for many of the vulnerable populations we serve or for building healthy communities. Public dollars are required to deliver these core components of public health nursing and our Constitution – 'life, liberty, pursuit of happiness, and enjoyment of the rewards of their own industry. Infectious diseases do not recognize insurance status or income levels, private providers may not reach out to one another forming strong safety nets, communities may not know best practices in safety and obesity prevention, and grandparents may not know the latest in how children's brain and behaviors develop, but public health nurses come to their work with the right skills to fill those needs. Continued funding of Public Health Nursing work is critical to Alaska's successful future.

Chlamydia

SOPHN invested roughly $3,800,000 on STI related services—this covered the cost of screening and treating infected individuals *and* preventing the spread of chlamydia and other sexually transmitted infections through contact investigation and health promotion efforts. As a result, we were able to avert an additional cost of $1,407,780 (estimated). If not for the up-front investment, the cost would have totaled roughly $5,208,000.

1. ~12% or workload is devoted to STI related services
   ~12% x $31,803,800 total SOPHN budget
   ~$3,816,456 spent on STI related services



Practice Story:

In FY 15, public health nurses at a State Public Health Center began a systematic initiative to improve targeted STI services (education, screening, treatment and contact investigation) to high risk groups in the community. Staff recognized that while many organizations like half-way houses and substance abuse treatment centers had PHN assistance, the homeless were a population in which it had been difficult to integrate and gain trust. One nurse was dedicated to gain familiarity and trust amongst the chronically homeless. Following a literature review, staff identified a best practice technique to offer food incentives in combination with STI services at the local homeless shelter. These first time services were offered on site and one of the homeless clients came back positive for gonorrhea. Due to the transient nature of this population, the public health nurse was challenged to locate the client again to offer treatment and complete the contact investigation. After multiple attempts to find the individual, the nurse's persistence was rewarded and she was finally able to connect with the client to explain the infection, offer her treatment, and risk reduction strategies.

The client's story was quite sad. Due to her homeless status and concerns for personal safety, she had been trading sex for security and housing. One of the individuals she had taken shelter with had infected her. The client dealt with the news bravely, and preferred to talk to one of her partners herself to inform him that he also would need testing and treatment to stop the spread of the infection. Using the Expedited Partner Therapy protocol, the public health nurse was able to send the client home with medication for one individual. The other contact was to be screened and treated by the public health nurse.

The second contact proved more difficult to track down, but between the original client and the nurse, the client agreed to come to a local bar where the nurses were offering screening later that week, again as a strategy to access the highest risk population. The contact did come to the bar, and was successfully treated for infection.

When the nurse followed up with the original client, the client disclosed to the nurse that she had been beaten when she informed her primary partner about the infection. The public health nurse then linked the client with local domestic violence counseling and safety resources.

Finally, to further assist the original patient, the public health nurse was able to successfully schedule the client with the itinerating nurse practitioner to address her reproductive and preventive health needs that had been neglected for over a decade.

The outcome of the relationship the public health nurse built with the homeless shelter and the local bar, specifically their willingness to allow group education, screening, and treatment services, demonstrated to the public health nursing team that their efforts to improve targeted outreach in various community locations were fruitful, and provided value to the citizens of the community. We, as public health nurses, recognize that this issue is just one piece to this client's current situational puzzle. We do understand the complexity that goes along with being homeless and the multiple organizations that all play a role in empowering and supporting clients on their road to health. However, this example highlights the return on investment from public health nurses working to reduce the spread of disease, advocating and intervening in cases of domestic violence, and raising awareness of STIs among vulnerable groups.

Outcome – All Alaska cases[2]

	AK cases[3]	AK Cases Averted[4]	AK costs averted	Cost per case averted[5]
AK - CT female	3902	1951	$1,136,262.40	$582.40
AK - CT male	1824	912	$43,776..00	$48.00
AK- GC female	658	329	$186,345.60	$566.40
AK - GC male	655	328	$41,396.00	$126.40
Total - CT	5726	2863		
Total - GC	1323	657		
Total cost averted	**$1,407,780.00**			

2. Public health nurses, as a result of our population-based work, contribute to providing STI services to all Alaskans
3. Based on 2014 data
4. For every 2 STI cases treated, 1 case is averted
5. Based on 2010 National costs per case plus 60% based on Alaska health care costs related to national averages

As presented in the beginning, the SOPHN invested roughly $3,800,000 on STI related services—this covered the cost of screening and treating infected individuals *and* preventing the spread of chlamydia and other sexually transmitted infections through contact investigation and health promotion efforts. As a result, we were able to avert an additional cost of $1,407,780 (estimated). If not for the up-front investment, the cost would have totaled roughly $5,208,000.